The average mortality for the series was 28 per cent., varying from 50 per cent. in infants to 18 per cent. in adults. The least unfavorable period is between three and ten years of age. Twenty per cent. of the patients die as the result of the primary illness, or of a recurrence of it, or of some other complication or intercurrent disease. Only 8 per cent. die because of the empyema, and half of these die in the first forty-eight hours. Twenty-three per cent. of the patients that recovered had more or less trouble with the healing of their wounds—1 out of every 4.

The Use of Silver Foil in Surgery.—Lexer (*Zentralbl. f. Chir.*, 1915, xlii, 217) found silver foil very advantageous, especially, in wounds of the face and in skin transplantations. On the first change of the dressings, a week after operation, or when the sutures have been left three weeks or more under a cast, they are dry and show no surrounding inflammation, even in regions rich in perspiration. It was shown by bacteriological examinations that the sutures and surrounding parts remained sterile when covered by the silver foil. Eczema and maceration of the skin did not occur when the wound secretions were abundant and kept the dressings moist after delay in changing them. A striking feature is the fine smooth scar which is dependent upon the absence of infection. If the silver foil is washed away with benzin and the scar examined by a magnifying glass, three or four days afterward, the new epidermis is seen covering this scar smoothly from one edge of the wound to the other. This gives the sutured wound a better hold so that one may use very fine sutures. This is of special advantage in plastic operations on the face. The sutures may be removed after five days and the wound covered by more silver foil as long as a dressing seems necessary. Because of this rapid covering of the wound by the skin, Lexer employed the silver foil in skin transplantations and thinks there is no better method. Here, also, he employs only one layer of the silver, instead of four layers as by Halstead who introduced this method in 1894, and covers the silver with smooth sterile gauze. On the removal of the dressing at the end of a week the grafts are found healed. In some spots the epidermis is raised by blood or pus, as when granulations have been removed, but these spots are quickly covered by epidermis after the lifted parts are removed and the underlying granulations have been covered by silver foil. Lexer applied the method to granulating wounds and found that good smooth granulations developed and excess was prevented by the silver. Unhealthy granulations with much secretions were cleansed rather rapidly by the silver.

Treatment of Gunshot Wounds of the Abdomen by Compressing Bandages.—Kelling (*Zentralbl. f. Chir.*, 1915, xlii, 241) after calling attention to the high mortality of these cases and the associated conditions affecting the mortality, says that the first efforts of the surgeon should be directed toward localizing as much as possible the results of the injury to the gastro-intestinal tract. The patients should lie quiet and should be carried to the place for treatment. Scheibe reported that those who lay two or three days on the battle field, showed favorable results. Those wounded below the umbilicus should have the upper part of the trunk raised, while those wounded in the epigastrium should have the pelvis raised. Those with gunshot wounds in the right or left flank should lie on the side injured, because gravity is of the first importance in localizing the escaped gastro-intestinal contents. Kelling urges the use of a compressing bandage of the abdomen. It will be most effective in those cases in which the wound is about in the middle of the abdomen. It will be somewhat less effective in wounds of the epigastric or hypochondriac regions because it can only indirectly compress the space under the ribs above, by contracting the volume of the abdominal cavity. The pressure does not operate to force out the intestinal contents into the surrounding peritoneal cavity, but does quite the reverse. It allows no space into which escaping contents can find its way. Hemorrhage from wounded parenchymatous organs is affected in a similar manner. It is especially important, during transportation, to prevent or diminish changes in the position of the viscera which favor greater escape of intestinal contents, by the use of the compressing bandage. The method of treatment was tested, experimentally, in six large rabbits. The same wound was made on each of two rabbits, the compression bandage being employed in one and not in the other. In one of the first two rabbits, through a small epigastric incision, a 1.5 cm. opening in the anterior wall of the stomach was made. Fluid contents were allowed to escape, when the stomach was replaced, the wound in the abdominal wall closed and the compression bandage applied. The rabbit was killed by chloroform two days later and the section showed the whole abdominal cavity free of peritonitis. The incision ring in the stomach was adherent to the liver and omentum. The second animal, on which exactly the same operation was done, was killed after sixteen hours. General peritonitis with the intestines diffusely red and much fluid in the peritoneal cavity were found. The incision wound in the stomach was in no way adherent. The results in the other four rabbits were very similar. The employment of the compression bandage is most effective when applied immediately after the wound is received.

Ileus Duplex.—HANDLEY (*Lancet,* May 1, 1915, p. 900) presents a study of his observations of the pathology of this condition in the living. Ileus duplex is a condition in which, as the result of a pelvic peritonitis, there is obstruction of the intestine at two points: (*a*) in the ileum, at a point about 3 feet above the ileocecal valve, and (*b*) in the sigmoid colon at the junction of its iliac and pelvic portions. These are the points at which the ileum and colon respectively cross the brim of the true pelvis to enter the pelvic cavity. The segments of intestine paralyzed are two in number: (1) the portion of ileum contained in the pelvis, that is to say, about the lower 3 feet, excluding the last 2 inches; and (2) the portion of the large bowel contained in the true pelvis, *i. e.,* the lowest portion of the pelvic colon and the upper portion of the rectum. Three main reasons are given for its importance: (1) because the condition, though curable by appropriate treatment in the early stage, often passes unrecognized under the pseudonym of general peritonitis; (2) because the duplex nature of the obstruction has not hitherto been appreciated; and (3) because, as might be expected, defects in the pathological conception of the